AMENDED IN SENATE MAY 15, 2008

AMENDED IN SENATE APRIL 7, 2008

SENATE BILL No. 1332

Introduced by Senator Negrete McLeod

February 20, 2008

An act to add and repeal Article 2.75 (commencing with Section 14087.481) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 1332, as amended, Negrete McLeod. Medi-Cal: managed care.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons.

Existing law allows the department to contract with one or more prepaid health plans in order to provide Medi-Cal benefits.

Existing law allows the Director of Health Care Services to contract with any qualified individual, organization, or entity, including counties, to provide services to, or arrange for or case manage the care of, Medi-Cal beneficiaries.

This bill would establish the Medi-Cal Managed Care Pilot Program. Under this program, until July 31, 2015, and subject to the receipt of any necessary federal waivers, the department would require seniors and persons with disabilities in the Counties of Riverside and San Bernardino who are not expressly excluded from enrollment to enroll in a Medi-Cal managed care health plan. The bill would require the department, by ~~March~~ *July* 1, 2009, to complete an implementation plan containing specified elements and prepared in consultation with a ~~local~~ *health care* stakeholder advisory committee, which this bill would

require the department to convene in accordance with specified criteria, and to take certain other actions relating to the development of the pilot program. The bill would impose various requirements on managed care plans participating in the program. The bill would require the department to seek federal approval for the program, and to conduct and, by March 1, 2014, report to the Legislature the results of, an evaluation of the program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 2.75 (commencing with Section 14087.481) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 2.75. Medi-Cal Managed Care Pilot Program

14087.481. (a) It is the intent of the Legislature in enacting this article to improve the quality of health care for seniors and persons with disabilities by testing standards for timely access to care, enrollee assistance, appropriate accommodations, and other measures through the pilot program authorized by this article, and to provide for an evaluation of the results.

(b) It is further the intent of the Legislature that the pilot program be conducted in the Counties of Riverside and San Bernardino in a manner that does all of the following:

(1) Recognizes the multiple and complex needs of low-income seniors and persons with disabilities, including the need for specialized care and out-of-network services.

(2) Provides exemptions for individuals with a medical condition that would not be adequately served by the pilot program.

(3) Respects and maintains enrollees' existing, longstanding provider relationships whenever possible.

(4) Focuses on prevention and wellness programs to improve health outcomes for seniors and persons with disabilities.

(5) Tests performance standards for Medi-Cal managed care plans that address the specific needs of seniors and persons with disabilities.

(6) Tests clinical and service measures to ensure that Medi-Cal beneficiaries receive appropriate care and are provided assistance in obtaining access to care.

(7) Identifies best practices for providing health care services to low-income seniors and persons with disabilities.

(8) Involves stakeholders in planning, implementation, and evaluation.

(9) Provides sufficient compensation for coordination of care among multiple providers and care management by providers.

(10) Provides sufficient payment rates to attract and retain providers, particularly those with specialized expertise in providing care to seniors and persons with disabilities.

(11) Promotes accessibility, including physical and communications access, for all seniors and persons with disabilities.

14087.482. (a) For purposes of this article, the following definitions shall apply:

(1) "Medi-Cal managed care plan contracts" means those contracts entered into with the department by any individual, organization, or entity pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of this chapter, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8.

(2) "Medi-Cal managed care health plan" *or "health plan"* means an individual, organization, or entity operating under a Medi-Cal managed care plan contract with the department under this chapter or Chapter 8 (commencing with Section 14200), which is licensed as a full service health care service plan in compliance with the Knox-Keene Health Care Service Plan Act of 1975.

(3) "Seniors and persons with disabilities" means Medi-Cal beneficiaries eligible for benefits through age, blindness, or disability, as defined in Title XVI of the Social Security Act (42 U.S.C. Sec. 1381 et seq.) *who are not excluded persons, as defined in paragraph (4)*.

(4) "Excluded persons" means persons who are simultaneously qualified for full benefits under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.) and Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.), persons who are eligible for Medi-Cal with a share of cost, except to the extent that these persons are made mandatory enrollees in a Medi-Cal managed

care health plan under Article 2.8 (commencing with Section 14087.5), persons enrolled in the California Children's Services Program under Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and persons who, at the time they are to be mandatorily enrolled in the pilot program described in this article, are either on a major organ, except kidney, transplant list or in one of the following home- and community-based waivers under Section 1396n of Title 42 of the United States Code:

(A) In-Home Medical Care Waiver.

(B) Nursing Facility Subacute Waiver.

(C) Nursing Facility Level A/B Waiver.

(b) (1) Notwithstanding subparagraph (B) of paragraph (1) of subdivision (c) of Section 14089, and paragraph (3) of subdivision (b) of Section 53845 of, subparagraph (A) of paragraph (3) of subdivision (b) of Section 53906 of, and subdivision (a) of Section 53921 of, Title 22 of the California Code of Regulations, and subject to subdivision (c), the department shall ~~require that~~ *provide all* seniors and persons with disabilities who reside in the Counties of Riverside and San Bernardino, and who are not excluded persons, ~~as defined in paragraph (4) of subdivision (a), be required to enroll~~ *with the ability to enroll* in a Medi-Cal managed care health plan in accordance with the requirements set forth in this article and consistent with applicable state and federal laws. ~~This~~ *The choice to enroll in a health plan shall be provided to seniors and persons with disabilities who reside in the Counties of Riverside and San Bernardino upon enrollment, or, if the individual is an existing Medi-Cal beneficiary, through notice.*

(2) Individuals who select Medi-Cal managed care pursuant to this section shall remain enrolled in a managed care plan until the individual's next annual redetermination, unless the enrollee is exempted pursuant to the continuity of care provisions or medical exemption provisions of Section 14087.487. At the time of the annual redetermination, the enrollee shall have a choice to return to fee-for-service Medi-Cal. Individuals not subject to annual redetermination shall be given the option to return to fee-for-service on an annual basis.

(3) Individuals who fail to select fee-for-service or a managed care plan pursuant to this section shall be enrolled in managed care, and shall be assigned to a managed care plan pursuant to

Section 14087.491. Individuals subject to assignment to Medi-Cal managed care pursuant to this paragraph shall be permitted to opt out of managed care, without cause, within the first 60 days of enrollment in a managed care plan. Nothing in this paragraph precludes an enrollee from seeking an exemption from managed care pursuant to Section 14087.487 after the 60-day period expires.

(4) Nothing in this section shall preclude an enrollee who is in one managed care plan from selecting a different managed care plan.

(c) This article shall not be implemented in a county without the official endorsement of that county's county-operated public hospital. ~~Access to fee-for-service Medi-Cal shall not be terminated until the enrollee has completed any care to be provided under the continuity of care provisions.~~

(d) Nothing in this section shall be construed to imply changes to existing services being provided by Medi-Cal managed care health plans in the pilot counties pursuant to this article.

(e) Services provided through the California Children's Services Program shall not be included in the pilot programs authorized under this article.

(f) Notwithstanding Section 14087.491, individuals meeting participation requirements for the Program for All-Inclusive Care for the Elderly (PACE) may select a PACE plan if one is available in that county.

~~(2) Nothing in this subdivision~~

(g) Nothing in this section is intended to limit existing authority provided by Article 2.8 (commencing with Section 14087.5).

~~(c)~~

(h) The department shall seek all necessary federal waivers to implement this article. The department shall submit to the Legislature all proposed state plan amendments, waiver amendments, and waiver applications, including amendments to the Medicaid state plan specifically outlining the reimbursement methodology developed pursuant to this article.

14087.483. No later than ~~March~~ *July* 1, 2009, the department shall develop an implementation plan for compliance with this article. The implementation plan shall be developed in consultation with the stakeholder advisory committee established pursuant to Section 14087.484. The implementation plan shall specifically address the multiple and complex needs of seniors and persons

with disabilities, and the specific strategies the department will use to ensure the provision of quality, accessible health care services under the pilot program, including at least all of the following elements:

(a) (1) Criteria, performance standards, and indicators to ensure compliance with this article. ~~The performance standards shall incorporate, at a minimum,~~ *Health plans shall comply with* existing statutory and regulatory requirements and protections applicable to two-plan model and geographic managed care plans, as well as those protections available under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code; the Knox-Keene Act)~~, but, in addition,~~. *Performance standards developed pursuant to this article* shall include specific standards in all of the following areas:

(A) Plan readiness.

(B) Availability and accessibility of services, including physical access and communication access.

~~(C) Benefit management and scope of services.~~

~~(D)~~

(C) Care coordination and care management.

~~(E)~~

(D) Beneficiary participation.

~~(F) Continuity of care, as described in Section 1373.96 of the Health and Safety Code.~~

~~(G)~~

(E) Measurement and improvement of health outcomes.

~~(H) Marketing, assignment, enrollment, and disenrollment.~~

~~(I)~~

(F) Network capacity, including travel time and distance and specialty care access.

~~(J)~~

(G) Performance measurement and improvement.

~~(K) Provider grievances and appeals, in accordance with subdivision (e).~~

~~(L)~~

(H) Quality care.

~~(M) Recordkeeping and reporting.~~

(I) Timely contact and screening of new enrollees to identify clinical and access needs.

(2) Any standards developed in addition to those described in paragraph (1) shall be guided by the Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions, published by the California Health Care Foundation, November 2005.

(b) (1) A process and timeline for enrollment and beneficiary selection of a health plan. The department shall assess and revise the health care options and enrollment process established pursuant to Section 14016.5 as necessary to ensure that they effectively meet the diverse and specific needs of seniors and persons with disabilities. The department shall explore the feasibility of developing a broker or enrollment support system to provide assistance to seniors and persons with disabilities who need enrollment assistance.

(2) The enrollment process developed pursuant to this subdivision shall include both of the following:

~~(A) Transition standards to ensure that there is no disruption in access to health care during the transition and enrollment process, and~~

(A) Provisions to ensure that Medi-Cal beneficiaries receive information and assistance related to their rights, including, but not limited to, the right to request any medical exemption ~~or procedure to delay or avoid mandatory enrollment in the pilot program when necessary, in accordance with the portion of the implementation plan developed pursuant to subdivision (h).~~ *from the pilot program when necessary, in accordance with Section 14087.487.*

(B) Identification of categories of seniors and persons with disabilities who may need special assistance in the enrollment process and those with special health care needs or other conditions that warrant immediate contact by a plan at initial ~~enrollment. In identifying these categories, the department shall include a review of fee-for-service Medi-Cal claims data and diagnosis codes, and a review of all known information from other programs and services providing assistance to seniors and persons with disabilities.~~ *enrollment.*

(c) Requirements for the coordination of services under managed care plans for beneficiaries receiving services from other state or local government programs or institutions.

(d) An appropriate awareness and sensitivity training program regarding the multiple and complex needs of seniors and persons with disabilities for all staff in the department's Medi-Cal Managed Care Office of the Ombudsman, in consultation with the stakeholder committee established under this article.

(e) (1) A system for ~~tracking, reporting,~~ responding to~~,~~ and resolving complaints or requests for assistance in a timely manner. The system shall be available 24 hours a day, seven days a week, shall include a statewide, toll-free "800" telephone hotline~~, and shall be accessible to those persons needing language assistance and those requiring adaptive technology. Urgent complaints shall be resolved within 24 hours and nonurgent complaints shall be resolved within 30 days. If complaints are not resolved within these periods, the enrollee may, at his or her discretion, disenroll from mandatory managed care and choose either another managed care plan available in his or her geographic region or may return to fee-for-service Medi-Cal. Enrollees shall be informed of this right at the time the complaint is made.~~ *for the pilot area.*

(2) The department shall develop and coordinate the response system and hotline in consultation with the Department of Managed Health Care's HMO Help Center and the Health Insurance Counseling and Advocacy Program administered by the California Department of Aging. ~~The department shall also require contracting health plans to establish internal patient advocate programs specifically available and accessible to persons with disabilities subject to mandatory enrollment in managed care.~~

(3) ~~The~~ *Public* complaint information shall be available to the stakeholder committee established under this article.

~~(f) All notices and administrative procedures at the departmental and health plan level shall be accessible to seniors or persons with disabilities through methods that may include, assistive listening devices, sign language interpreters, and translation in appropriate languages.~~

~~(g) Require that Medi-Cal managed care beneficiaries retain and are informed of all rights to grievances and appeals available under state and federal laws and regulations.~~

~~(h)~~

(f) An outreach and education program for seniors and persons with disabilities *in the pilot program* regarding enrollment options, rights and responsibilities under the pilot program, and the criteria

for a medical exemption under this article. The outreach and education program shall be developed in consultation with the local stakeholder committee, established pursuant to Section 14087.484, and shall include strategies to inform and coordinate with community organizations providing services to seniors and persons with disabilities.

~~(i) (1) The system for assessing, tracking, and enforcing the performance standards developed pursuant to this article. Compliance with the standards shall be a condition of contracting for Medi-Cal managed care, and the department shall ensure~~

(g) The system for assessing ongoing compliance of managed care plans consistent with the requirements of this article. The department shall cease new enrollments in ~~any health plan that it finds~~ *a health plan if it finds that the health plan* is not in substantial compliance with this article, and may cease enrollment in a health plan that fails to meet any provision of this article if the department determines that the failure to comply jeopardizes the health, safety, or access to quality care for beneficiaries.

~~(2) If enrollment is ceased pursuant to subparagraph (A), the department shall ensure that the beneficiary may enroll in another managed care plan, or if no other managed care plan is available, the beneficiary may enroll in fee-for-service Medi-Cal.~~

~~(j) The written policies and procedures that apply when a health plan or its contracting providers are unable to provide timely access to services to enrolled Medi-Cal beneficiaries.~~

~~(k)~~

(h) The specific methodology for developing capitation rates for Medi-Cal managed care plans enrolling seniors and persons with disabilities~~, including any adjustments that may be proposed to those rates for budgetary reasons. The methodology shall ensure that rates are actuarially sound and comply with Section 438.6(c) of Title 42 of the Code of Federal Regulations. The department shall ensure that the development of rates is based on data specific to seniors and persons with disabilities.~~

~~(1) In determining and evaluating capitation rates, the department shall take into account the full range of reimbursements for all covered medical procedures and services.~~

~~(2) The director may require Medi-Cal managed care health plans to submit financial and utilization data, as deemed necessary. The department shall ensure that the submission of financial and~~

~~utilization data does not place an undue burden on the health plans' ability to provide comprehensive, patient-centered care to all enrollees regardless of disability.~~

~~(3) The department shall develop a process for initial ratesetting, and for adjusting the capitation rates on an ongoing basis, to meet the restorative and health maintenance needs of seniors and persons with disabilities. The rate setting details shall be submitted to the Legislature on an annual basis.~~

~~(4) At least 120 days prior to the effective date of any contract with a managed care plan pursuant to this article, and annually thereafter, the department shall do all of the following:~~

~~(A) Provide the managed care plan with the opportunity to review and comment on the rate development methodology prior to the contract year for which the rates will be paid.~~

~~(B) Provide the managed care plan with the opportunity to provide comment on the draft rates and the rate manual providing the basis for those rates.~~

~~(C) Respond to managed care plan comments on the draft rates.~~

~~(5) Capitation rates shall be finalized prior to the contract year for which the rates will be paid, and shall be reviewed and updated at least annually to reflect changes in cost and utilization.~~

~~(6) If the department determines that the capitation rate is not sufficient to ensure an adequate network of providers to meet the needs of seniors and persons with disabilities, the department shall adjust the capitation rate to ensure an adequate network.~~ *in the pilot program. The methodology shall comply with Section 14087.486.*

~~(l)~~

(i) Budgetary projections of the effect of managed care expansion pursuant to this article on the total Medi-Cal budget for the 2009–10 to 2013–14, inclusive, fiscal years, including an evaluation of the cost-effectiveness of the expansion compared to providing Medi-Cal coverage to the same beneficiaries in fee-for-service Medi-Cal.

~~(m)~~

(j) The process and timeline for outreach, education, enrollment, and beneficiary selection of health plans and providers, including the health care options process and policies for assigning beneficiaries who do not choose a *fee-for-service* health plan within

30 days. The department shall develop assignment distribution policies consistent with Section ~~14087.489~~ *14087.491*.

~~(n)~~

(k) Outline any specific changes needed to the existing two-plan model's medical exemption process to accommodate seniors and persons with a disability~~, by addressing at least all of the following:~~

~~(1) The conditions necessary to be eligible for a medical exemption from the pilot program.~~

~~(2) The conditions warranting continuity of care through fee-for-service Medi-Cal on a permanent basis because of unique needs that cannot be met by the pilot program.~~

~~(3) The conditions warranting continuity of care through fee-for-service Medi-Cal on a temporary basis until the condition is stabilized.~~

~~(4) Administrative timelines and processes.~~

~~(5) Adherence to the existing standards specified in subparagraph (A) of paragraph (2) of subdivision (a) of Section 53887 of Title 22 of the California Code of Regulations and Section 1373.96 of the Health and Safety Code.~~ *consistent with Section 14087.487.*

~~(o) The proposed program evaluation, as required by Section 14087.491, including the process, timelines, and criteria for evaluating the pilot program.~~

(l) The process, timelines, and criteria for evaluating the pilot program required by Section 14087.493.

~~(p)~~

(m) Review of the current overlap in regulations and authority and recommendations for clear assignment of responsibilities to the department and the Department of Managed Health Care for ensuring compliance with all state and federal laws relevant to Medi-Cal managed care plans. *The Department of Managed Health Care shall retain its responsibility for ensuring consumer protections, adequacy of network, and financial solvency of the participating health plans. The Department of Health Care Services shall be responsible for ensuring compliance with additional standards appropriate for seniors and persons with disabilities within Medi-Cal.*

~~(q)~~

(n) Identify any additional state or federal legislation and authority needed to implement this article.

~~(r) (1) Develop, in consultation with the participating plans and the local stakeholder committee created pursuant to Section 14087.484, implement, and test a continuity of care process that meets all of the following criteria:~~

~~(A) Addresses the specialized care and treatment needs of seniors and all persons with a disability.~~

~~(B) Extends continuity of care rights to those entering Medi-Cal managed care from the Medi-Cal fee-for-service system.~~

~~(C) Extends continuity of care rights to cover all providers, including, but not limited to, physicians, specialists, and certified or licensed nurse midwives, who are actively treating the enrollee for a medical condition that qualifies under this article. For purposes of this paragraph, "actively treating" means providing treatment within the last 90 days before enrollment into the pilot program created pursuant to this article.~~

~~(D) Includes, at a minimum, medical conditions listed in subparagraph (A) of paragraph (2) of subdivision (a) of Section 53887 of Title 22 of the California Code of Regulations and Section 1373.96 of the Health and Safety Code.~~

~~(2) Any beneficiary granted a medical exemption from health plan enrollment pursuant to this article shall remain with the fee-for-service program until the medical condition has stabilized so that the individual may safely transition to the new provider and begin receiving care from a plan provider without deleterious medical effects, as determined by the treating physician or specialist in the Medi-Cal fee-for-service program. If the medical condition is not sufficiently stable to permit safe transfer, the beneficiary may choose to remain in fee-for-service Medi-Cal until the medical condition is stable.~~

~~(3) An enrollees in the pilot program shall have the choice to continue an established patient-provider relationship if his or her treating provider is a provider contracting with a Medi-Cal managed care plan in the service area, has available capacity, and agrees to continue to treat the beneficiary.~~

~~(4) Nothing in this subdivision shall imply changes to existing services carved out of Medi-Cal managed care health plans in the two counties.~~

~~(5) Services provided through the California Children's Services Program shall not be included in the pilot programs authorized under this article.~~

14087.484. (a) In preparing the implementation plan required by Section 14087.483, the department shall convene a ~~local~~ *health care* stakeholder advisory committee of 21 members to advise the department and the participating health plans on the implementation of this article. Committee members may serve for the entire duration of the pilot program.

(b) The ~~local~~ *health care* stakeholder advisory committee shall remain in place to advise the department regarding the implementation, continued operation, and evaluation of the pilot program and to advise health plans about the provision of services to seniors and persons with disabilities in the pilot program. *The health care stakeholder advisory committee shall also solicit input from seniors and persons with disabilities in the community regarding the performance and operation of the pilot program, and shall review publicly available data on grievances, complaints, and requests for disenrollment.*

(c) The committee shall include~~, but not be limited to,~~ the following participants:

~~(1) Medi-Cal beneficiaries who are persons with disabilities or seniors living in the Counties of Riverside and San Bernardino. At least one-half of the committee shall be comprised of these beneficiaries or their family members.~~

~~(2) Representatives of community-based organizations serving seniors and persons with disabilities in the Counties of Riverside and San Bernardino.~~

~~(3) At least one representative from each participating health plan.~~

~~(4) At least two physicians participating in the health plans.~~

~~(5) At least two representatives of contracting hospitals.~~

~~(6) At least one representative from each participating county government.~~

~~(7) One representative of the exclusive collective bargaining agents for hospital workers of affected hospitals.~~

(1) Six Medi-Cal beneficiaries who are persons with disabilities in the Counties of Riverside and San Bernardino.

(2) Two Medi-Cal beneficiaries who are seniors living in the Counties of Riverside and San Bernardino.

(3) One representative of a community-based organization serving persons with disabilities in the Counties of Riverside and San Bernardino.

(4) Two representatives from statewide advocacy organizations serving persons with disabilities.

(5) One representative from a statewide organization or local community-based organization serving seniors in the Counties of Riverside and San Bernardino.

(6) One representative from a statewide advocacy organization serving low-income communities.

(7) One representative from a local or statewide advocacy organization serving communities of color or multilingual communities.

(8) One representative from each participating health plan.

(9) Two physicians participating in the health plans.

(10) Two representatives of public hospitals contracting with one or both of the participating health plans.

(11) One representative of the exclusive collective bargaining agents for hospital workers of affected hospitals.

(d) Members of the committee selected pursuant to paragraphs ~~(1) and (2)~~ *(3), (5), and (7)* of subdivision (c) shall be nominated by local community-based organizations and disability organizations.

(e) The department may seek grants or other private funding sources for the operational and other costs necessary for the implementation of this section.

14087.485. Prior to initiating the pilot program authorized by this article, the department shall provide Medi-Cal managed care plans ~~in the counties designated for mandatory enrollment~~ with both of the following:

(a) (1) Identification of seniors and persons with disabilities who may need special assistance in the enrollment process and those with special health care needs or other conditions that warrant immediate contact by a plan at initial enrollment. ~~In identifying these beneficiaries, the department shall include a review of fee-for-service claims data and diagnosis codes, and a review of all known information from other programs and services a beneficiary may be receiving.~~

(2) ~~At least 120 days prior to enrollment, the~~ *The* department shall provide the list described in paragraph (1) to those entities administering the enrollment process and to the health plans to ensure that beneficiaries receive necessary assistance.

(b) A list of fee-for-service Medi-Cal providers who are actively providing services to beneficiaries *within the pilot area to allow the health plans to actively recruit these providers to participate in plan networks and maintain existing patient-provider relationships.*

14087.486. (a) The department shall develop capitation rates in a manner that ensures that rates are actuarially sound and comply with Section 438.6(c) of Title 42 of the Code of Federal Regulations. The department shall ensure that the development of rates is based on data specific to seniors and persons with disabilities.

(b) In determining and evaluating capitation rates, the department shall take into account the full range of reimbursements for all covered medical procedures and services.

(c) The director may require Medi-Cal managed care health plans to submit financial and utilization data, as deemed necessary. The department shall ensure that the submission of financial and utilization data does not place an undue burden on the health plans' ability to provide comprehensive, patient-centered care to all enrollees regardless of disability.

(d) The department shall develop a process for initial ratesetting, and for adjusting the capitation rates during the pilot program to meet the restorative and health maintenance needs of seniors and persons with disabilities.

(e) At least 90 days prior to enrollment of beneficiaries pursuant to this article, and annually thereafter, the department shall do all of the following:

(1) Provide the managed care plan with the opportunity to review and comment on the rate development methodology prior to the contract year for which the rates will be paid.

(2) Provide the managed care plan with the opportunity to provide comment on the draft rates and the rate manual providing the basis for those rates.

(3) Respond to managed care plan comments on the draft rates.

(f) Capitation rates shall be finalized prior to the contract year for which the rates will be paid, and shall be reviewed and updated at least annually to reflect changes in cost and utilization.

14087.487. (a) The department shall develop and implement policies and procedures to ensure continuity of care that provide for all of the following:

(1) Adherence to the existing standards for medical exemptions contained in subparagraph (A) of paragraph (2) of subdivision (a) of Section 53887 of Title 22 of the California Code of Regulations.

(2) Any additional conditions that would permit a beneficiary to be eligible for a permanent medical exemption from the pilot program based on the unique needs of seniors and persons with disabilities, or because certain needs cannot be met within the pilot program.

(3) Expedited timelines for reviewing and processing requests for medical exemptions pursuant to this article. No enrollee who has requested an exemption shall be required to enroll in a managed care plan until the exemption has been processed.

(4) Provisions that permit an enrollee, at his or her discretion, to disenroll from mandatory managed care and return to fee-for-service Medi-Cal if the enrollee's complaint is not resolved within the appropriate timelines pursuant to paragraph (1) of subdivision (e) of Section 14087.483 or is not resolved in compliance with Section 1368 of the Health and Safety Code, consistent with subdivision (d) of Section 14087.490, and the department finds that this failure poses a threat to the health of the enrollee. Nothing in this paragraph precludes an enrollee from selecting another managed care plan in the pilot program. Enrollees shall be informed of this right at the time the complaint is made.

(5) A requirement that participating health plans comply at all times with Section 1373.96 of the Health and Safety Code regarding continuity of care with terminated providers and with nonparticipating providers. If the provider actively treating the enrollee is not a participating provider and is not subject to Section 1373.96 of the Health and Safety Code, the beneficiary may request a medical exemption pursuant to Section 53887 of Title 22 of the California Code of Regulations. This provision applies with respect to all providers, including, but not limited to, physicians, specialists, and certified or licensed nurse midwives who are actively treating the enrollee for a medical condition that qualifies for an exemption under this article.

(6) A description of the conditions warranting continuity of care through fee-for-service Medi-Cal on a permanent or extended

basis because of a medical condition that may not be easily stabilized.

(7) A requirement that participating plans permit enrollees in the pilot program to continue an established patient-provider relationship if the treating provider contracts with the plan in the service area, has available capacity, and agrees to continue to treat the beneficiary.

(b) The policies and procedures developed pursuant to this section shall be developed in consultation with the participating plans and the health care stakeholder committee created pursuant to Section 14087.484. The policies and procedures shall meet all of the following criteria:

(1) Address the specialized care and treatment needs of seniors and all persons with a disability.

(2) Extend all existing continuity of care rights to those entering Medi-Cal managed care from the fee-for-service Medi-Cal program.

(3) Extend all existing continuity of care rights to cover all providers, including, but not limited to, physicians, specialists, and certified or licensed nurse midwives, who are actively treating the enrollee for a medical condition that qualifies under this article. For purposes of this paragraph, "actively treating" means providing treatment within the last 90 days before enrollment into the pilot program created pursuant to this article.

(c) Unless permanently exempted, any beneficiary granted a medical exemption from health plan enrollment pursuant to this section shall remain with the fee-for-service program until the medical condition has stabilized so that the individual may safely transition to the new provider and begin receiving care from a plan provider without deleterious medical effects, as determined by the treating physician or specialist in the fee-for-service Medi-Cal program. If the medical condition is not sufficiently stable to permit safe transfer, the beneficiary may choose to remain in fee-for-service Medi-Cal program until the medical condition is stable..

~~14087.486.~~

14087.488. The department shall, at all times, ensure that it complies with all provisions of this article, all applicable state and federal laws and regulations, and all applicable contracts. On an ongoing basis, the department shall do all of the following:

(a) Track, monitor, and report to the Legislature on the pilot program in the annual budget process and to the policy and fiscal committees of both houses of the Legislature.

(b) Ensure ongoing compliance of participating health plans and providers with this article and all applicable state and federal laws and regulations *pertaining to the program*.

(c) Develop the pilot program in a manner that accomplishes all of the following:

(1) Protects the safety net providers in the community.

(2) Recognizes the multiple and complex needs of seniors and persons with disabilities, including the need for specialized care and out-of-network services.

(3) Provides sufficient compensation for coordination of care among multiple providers and care management by providers.

(4) Reflects the need to attract and retain providers, particularly those with specialized expertise in the care of ~~persons with special needs.~~ *seniors and persons with disabilities.*

(d) Make all relevant notices accessible to seniors or persons with disabilities through methods that may include, but need not be limited to, assistive listening devices, sign language interpreters, and translation in appropriate languages.

(e) Require that Medi-Cal managed care beneficiaries retain and are informed of all rights to grievances and appeals processes available under state and federal laws and regulations.

~~14087.487.~~

14087.489. (a) (1) Enrollment in the pilot program authorized by this article shall commence no later than ~~September 1, 2009~~ *January 1, 2010*. Prior to implementing *enrollment in* the pilot program, the department shall conduct a readiness review to ensure the readiness and the ability of the health plans to serve the special needs of ~~this population~~ *seniors and persons with disabilities*, and to comply with all requirements of this article, applicable state and federal laws, and relevant performance standards and contract requirements. To accomplish the readiness review, the department may contract with an independent contractor to review each participating health plan, which may include a review of a health plan's site.

(2) In determining readiness, each participating health plan shall demonstrate all of the following:

~~(A) The existence of an appropriate provider network within each service area, which shall include a sufficient number of all of the provider types necessary to furnish comprehensive services to seniors and persons with disabilities.~~

~~(B) Evidence that the health plan has a sufficient number of providers with the specific competencies, literacy, experience, and expertise to provide services to the population to be enrolled.~~

~~(C) Prior to securing a contract pursuant to this article, and on an ongoing basis, that the health plan has an active recruitment and retention program to secure contracts with providers providing services under Medi-Cal fee-for-service to beneficiaries who will be enrolled, that it has secured those contracts, and that the providers will be available to enrollees on the same basis as all other plan providers.~~

~~(D) Evidence that the plan has specific policies, procedures, and protocols to ensure timely access to the specialists, subspecialists, specialty care centers, ancillary therapists, and providers of specialized equipment and supplies, including durable medical equipment, either through health plan providers or through referrals to specialists outside the plan, including those providers outside of the plan network or geographic service area. For purposes of this subparagraph, "access" shall include physical access for individuals with disabilities, consistent with subparagraph (N).~~

~~(E) Evidence that the plan has adequate policies and procedures in place to ensure that persons enrolled pursuant to this article secure standing referrals, consistent with the requirements of the Knox-Keene Act, to the appropriate specialists, subspecialists, and specialty care centers necessary to ensure continuity of care and to meet their ongoing care and treatment needs.~~

~~(F) Evidence that the plan has a sufficient number of providers, service locations, and service hours, and sufficient types of appropriate providers, to ensure adequate geographic access, availability of services during normal business hours, and availability of emergency services within the service area 24 hours per day, seven days per week.~~

~~(G) Evidence that the plan provides access to reproductive services, including procedures for providing female seniors and females with disabilities with direct access to an obstetrician-gynecologist to provide women's routine and~~

~~preventive health care services, and to ensure that pregnant women with disabilities at a high risk of poor pregnancy outcome for the mother or the child are referred to appropriate specialists, including perinatologists, and have access to genetic screening with appropriate referrals.~~

(A) The existence of an appropriate provider network within the two counties, which shall include a sufficient number of all of the provider types necessary to furnish comprehensive services to seniors and persons with disabilities.

(B) (i) Evidence that the plan has specific policies, procedures, and protocols to ensure timely access to the specialists, subspecialists, specialty care centers, ancillary therapists, and providers of specialized equipment and supplies, including durable medical equipment, either through health plan providers or through referrals to specialists outside the plan, including those providers outside of the plan network or geographic service area. For purposes of this subparagraph, "access" shall include physical access for individuals with disabilities, consistent with subparagraph (J).

(ii) Evidence that the plan has written policies and procedures in place that apply when contracting providers are unable to provide timely access to services to enrolled Medi-Cal beneficiaries, including provision for referrals for out-of-network care.

(C) Evidence that the plan has adequate policies and procedures in place to ensure that persons enrolled pursuant to this article secure standing referrals, consistent with the requirements of the Knox-Keene Act, to the appropriate specialists, subspecialists, and specialty care centers necessary to ensure continuity of care and to meet their ongoing care and treatment needs.

~~(H)~~

(D) Evidence that the plan provides an opportunity for members to select a specialist as a primary care provider, as defined in subdivision (gg) of Section 53810 of Title 22 of the California Code of Regulations.

~~(I)~~

(E) Evidence that the plan provides access to all of the following services:

(i) Inpatient and outpatient rehabilitation services through providers accredited by the Commission on Accreditation of

Rehabilitation Facilities (CARF) or other similar accreditation organization.

(ii) Applied rehabilitative technology.

(iii) Speech pathologists, including those experienced in working with significant speech impairment, persons with developmental disabilities, and persons who require augmentative communication devices.

(iv) Occupational therapy and orthotic providers.

(v) Physical therapy.

(vi) Low-vision centers.

~~(J)~~

(F) Evidence that the Medi-Cal managed care health plans involved in the pilot program provide access to assessments and evaluations for wheelchairs that are independent of durable medical equipment providers and include, when necessary, a home assessment.

~~(K) Evidence that Medi-Cal managed care health plans involved in the pilot program are able to provide communication access to seniors, persons with disabilities, and those who are limited English proficient in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language interpreters, captioning, pad and pencil, or written translations and oral interpreters, and that all those Medi-Cal managed care health plans are in compliance with the cultural and linguistic requirements set forth in subdivision (c) of Section 53853 and Section 53876 of Title 22 of the California Code of Regulations.~~

~~(L) Evidence that the plan will have a process in place to do the following:~~

~~(i) Contact, within 30 days of enrollment, each enrollee identified by the department as having a special health care need or a need of assistance securing necessary health care services. This contact and all subsequent timeframes set forth under this subparagraph are contingent upon the department meeting its obligations set under subdivision (a) of Section 14087.489.~~

~~(ii) Stratify risks of those contacted pursuant to this subparagraph, identify any accommodation needs such as interpreters, language spoken, alternative format requirements, and identify any urgent medical needs.~~

~~(iii) For those identified by the plan as being high risk, develop a care plan within 60 days of the initial contact. The care plan shall be both of the following:~~

~~(I) Developed in consultation with, and with the consent of, the enrollee or his or her designated representative.~~

~~(II) Updated at the request of the enrollee or his or her designated representative, when there is a significant change in the health or services needs of the enrollee, and at least annually.~~

~~(iv) Nothing in this subparagraph shall limit the existing plan requirement to facilitate an enrollee's 120-day health assessment.~~

~~(M) Evidence that the plan has the staff and systems in place to coordinate care for enrolled seniors and persons with disabilities across all settings, including coordination of discharge to appropriate services within and outside of the plan's provider network.~~

~~(N) Evidence that the plan assesses its participating primary care providers and high utilization specialists to determine whether they comply with Titles II and III of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12131 et seq., and Sec. 12181 et seq., respectively), and all relevant state and federal laws and regulations, including, but not limited to, physically accessible facilities and services, accessible communication formats and methods, and other specialized facilities, equipment, and services that may be necessary to afford accessible care to seniors and persons with disabilities, as identified by the stakeholder advisory committee established pursuant to this article. Each participating plan shall demonstrate the ability to identify and communicate to potential enrollees the level and type of service accessibility offered by providers in the network.~~

~~(O) Evidence that the plan and its participating providers will utilize informational materials and deliver services in a manner to meet the linguistic and other special communication needs of seniors and persons with disabilities, including, but not limited to, providing information in an understandable manner, maintaining toll-free telephone hotlines, and offering ombudsmen services.~~

~~(P) Evidence that the plan has developed and will implement a clear, timely, and fair process for accepting and acting upon complaints, grievances, disenrollment requests, and appeals regarding coverage or benefits that meets the department's requirements pursuant to subdivision (e) of Section 14087.483,~~

~~and the relevant provisions of the Knox-Keene Act in a manner that is accessible to seniors and persons with disabilities.~~

~~(Q) Evidence that the plan will ensure stakeholder and member participation in advisory groups for the planning, development, and ongoing activities related to the provision of services for seniors and persons with disabilities, and that the plan will communicate and coordinate with community agencies serving low-income seniors and persons with disabilities.~~

~~(R) Evidence that the plan contracts with a sufficient number of traditional and safety net providers to ensure access to care and services, and to preserve the local community's capacity to provide care and services, for uninsured and other safety net populations.~~

~~(S) Evidence that the plan has developed specific strategies and policies to inform seniors and persons with disabilities of procedures for obtaining nonemergency transportation services to service sites that are offered by the plan or are available through the Medi-Cal program.~~

~~(T) Specific strategies the plan will employ to monitor and improve the quality and appropriateness of care for seniors and persons with disabilities.~~

(G) Evidence that Medi-Cal managed care health plans involved in the pilot program are able to provide communication access to seniors, persons with disabilities, and those who are limited English proficient. This communication must be provided in a manner that is understandable and usable to people with reduced or no ability to speak, see or hear, or who have limitations in learning, comprehension, or ability to communicate in English. Materials must be provided in alternative formats or through other methods necessary to ensure effective communication, including assistive listening systems, sign language interpreters, captioning, or written translations and oral interpreters. These alternative communication methods shall be provided in accordance with the preferences of the enrollee.

(H) Evidence that the plan will have a process in place to do the following:

(i) Contact, within 30 days of enrollment, each enrollee identified in advance for the plan by the department as having any special health care needs, access requirements or a needs for assistance in securing necessary health care services.

(ii) Identify any accommodation needs such as interpreters, language spoken, alternative format requirements, and identify any urgent medical needs.

(iii) For those identified by the plan as being high risk, provide referral to a care coordinator and develop a care plan within 60 days of the initial contact. The care plan shall be both of the following:

(I) Developed, in consultation with, and with the consent of, the enrollee or his or her designated representative.

(II) Updated at the request of the enrollee or his or her designated representative, when there is a significant change in the health or services needs of the enrollee, and at least annually.

(I) Evidence that the plan has the staff and systems in place to coordinate care for enrolled seniors and persons with disabilities across all settings, including coordination of discharge to appropriate services within and outside of the plan's provider network when necessary.

(J) Evidence that the plan assesses its participating primary care providers and high utilization specialists to determine whether they are accessible and usable by persons with disabilities in compliance with Titles II and III of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12131 et seq., and 42 U.S.C. Sec. 12181 et seq., respectively), and all relevant state and federal laws and regulations. Each participating plan shall demonstrate the ability to identify and communicate to potential enrollees the level and type of service accessibility offered by providers in the network.

(K) Evidence that the plan contracts with a sufficient number of traditional and safety net providers to ensure access to care and services, and to preserve the local community's capacity to provide care and services, for uninsured and other safety net populations.

(L) Evidence that the plan has developed specific strategies and policies to inform seniors and persons with disabilities of procedures for obtaining nonemergency transportation services to service sites that are offered by the plan or are available through the Medi-Cal program, and that the plan ensures that the transportation is provided, consistent with the current Medi-Cal managed care benefit provisions in the pilot area.

~~(U)~~

(M) Evidence that the plan has specific strategies in place to communicate and coordinate services with relevant community agencies and programs serving seniors and persons with disabilities, including, but not limited to, regional centers, independent living centers, county health, mental health, and social service agencies, area agencies on aging, and relevant nonprofit community-based organizations.

~~(V)~~

(N) Evidence that the plan has executed, at a minimum, memoranda of understanding with the county mental health managed care plan in the county, regional centers in the service area, and the local California Children's Services (CCS) office.

(b) The department shall coordinate with the Department of Managed Health Care in conducting facility site reviews of the plan to assess plan and provider readiness in a manner that eliminates duplication and burdens on plans and their providers.

~~14087.488.~~

14087.490. The department shall ensure that health plans contracting to provide services pursuant to this article shall meet the following requirements at all times:

(a) Ensure timely access to specialists and specialty care within or outside of the plan's network, including specialists, subspecialists, specialty care centers, ancillary therapists, and specialized equipment and supplies, including durable medical equipment.

(b) Ensure that persons with disabilities at all times have access to accessible, appropriate care, ~~including, but not limited to, rehabilitation services, applied rehabilitative technology, speech pathologists, occupational therapy, low-vision centers, wheelchair services, and any other services or providers that may be identified by the local stakeholder advisory committee established in Section 14087.484 as necessary to meet the needs of seniors and persons with disabilities.~~

~~(c) Track, monitor, and provide to the department all contract deliverables, including, but not limited to, quality improvement systems, utilization management policies and procedures, reliable service utilization and cost data, quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.~~ *as required by this article.*

(c) The cultural and linguistic requirements set forth in subdivision (c) of Section 53853 and Section 53876 of Title 22 of the California Code of Regulations.

(d) ~~Establish~~ *Maintain* a grievance system pursuant to the requirements of Section 1368 of the Health and Safety Code, and establish a procedure for the expedited review of grievances pursuant to the requirements of Section 1368.01 of the Health and Safety Code. Urgent complaints or grievances shall be resolved within 72 hours, and nonurgent complaints or grievances shall be resolved within 30 days. At any time during the complaint process, the enrollee may request a change of health plan. If a complaint or grievance is not resolved within the periods set forth in this subdivision *and Section 1368 of the Health and Safety Code*, the enrollee may petition the department to disenroll from the plan and enroll in fee-for-service Medi-Cal~~. An enrollee shall be informed of these rights at the time he or she files a complaint or grievance. The department shall review all requests to disenroll from a plan and enroll in fee-for-service Medi-Cal within existing timeframes applicable to processing medical exemptions.~~

~~(e) Provide clear, timely, and fair processes for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits consistent with state and federal law.~~

~~(f) Maintain a toll-free "800" nurse advice telephone service available and accessible to seniors and persons with disabilities to respond to urgent clinical needs.~~*, pursuant to Section 14087.487.*

(e) Maintain a toll-free "800" nurse advice telephone service available and accessible to seniors and persons with disabilities, including those with hearing or other communication disabilities, to respond to urgent clinical needs.

~~(g)~~

(f) Demonstrate to the department and the Department of Managed Health Care compliance with applicable state and federal laws and regulations, all readiness criteria and performance standards developed by the department, effective implementation of the plan's proposed policies and procedures by the plan and its providers, contract deliverables, and other submissions.

~~(h) (1) Annually~~

(g) (1) By September 30, 2009, and annually thereafter, each health plan shall produce, publish, and file with the department an accessibility plan, which shall do both of the following:

(A) Set goals, list priority activities, and commit resources for increasing accessibility to network provider services.

(B) Include goals related to disability, literacy, and competency training for health plan staff and health care providers; ongoing identification of existing physical, equipment, communication, transportation, and policy barriers encountered by enrollees; strategies for removing the identified barriers; and collection and incorporation of feedback from consumers with disabilities and chronic conditions.

~~(2) The department shall encourage participating health plans to~~

(2) Participating health plans shall, when feasible, partner with academic and research institutions to identify and test new clinical and service performance measures specific to the unique needs of seniors and persons with a disability.

(3) The department shall require contracting health plans to establish internal patient advocate programs specifically for persons with disabilities enrolled in managed care.

~~14087.489. (a) Beneficiaries who are eligible and required to join a~~

14087.491. (a) Beneficiaries who select Medi-Cal managed care ~~plan~~ pursuant to this article and who do not select a Medi-Cal managed care plan within 30 days shall be assigned to a health plan by the enrollment contractor. The contractor shall assign a beneficiary to a health plan that includes one or more of his or her existing providers of record, including, but not limited to, his or her primary care provider, specialist, or clinic. The department shall establish the Medi-Cal providers of record based on a review of Medi-Cal paid claims history.

(b) If a beneficiary chooses to not enroll in a health plan, the contractor shall assign the beneficiary to a health plan as follows:

(1) If the beneficiary's primary physician or specialist has a current contract with the publicly sponsored local initiative and the commercial plan, or, if the beneficiary's primary physician or specialist does not have a contract with either plan, the beneficiary shall be assigned to either plan based on the Medi-Cal member

default assignment procedures set by the Medi-Cal performance-based auto-assignment algorithm.

(2) If a beneficiary's primary physician or specialist has a current contract with only one of the plans, the beneficiary shall be assigned to that plan.

(3) Nothing in this section shall preclude the beneficiary from choosing to enroll in a specific plan or from requesting a medical exemption.

~~14087.490.~~

14087.492. The department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code for the implementation of this article.

~~14087.491.~~

14087.493. (a) The department shall contract with an independent third-party organization to conduct an evaluation of the pilot program, the results of which shall be reported to the Legislature by March 1, 2014. The evaluation shall be based on data collected during the three-year duration of the pilot program, and shall include, but not be limited to, all of the following:

(1) The impact of enrollment on seniors and persons with disabilities, including access to care, outcome measures, enrollee satisfaction, continuity of care, and health plan compliance with all applicable standards and guidelines, including the performance standards developed pursuant to this article.

(2) An analysis of the impact upon access to care for managed care compared to fee-for-service Medi-Cal beneficiaries, including, but not limited to, access to a medical home, primary care physician, specialty care, disease management programs.

(3) An analysis of quality of care provided in the managed care versus fee-for-service delivery models, *including access to preventive services and preventable hospitalizations*.

~~(4) An analysis of the impact on access to care for uninsured persons, including an assessment of the impact on the public and private safety net in the counties, and an analysis of the financial impact on public and private hospitals and clinics providing substantial services to uninsured, low-income persons.~~

~~(5)~~

(4) Enrollee satisfaction.

~~(6)~~

(5) The effectiveness of the implementation plan and the readiness program.

~~(7)~~

(6) The effectiveness of the standards tested.

(b) The department may seek funding from foundations, nonprofit organizations, and the federal government to implement this section.

~~(c) Prior to the completion of the evaluation required pursuant to this section, the Counties of Riverside and San Bernardino may review and provide comment regarding the evaluation. The department shall hold a public meeting to accept comment from interested stakeholders in each affected county on the impact of the pilot program on the quality-of-care provided to seniors and persons with disabilities.~~

(c) Prior to the completion of the evaluation required pursuant to this section, the health care stakeholder committee and other interested stakeholders shall be provided an opportunity to review and comment on the report. The department may collaborate with the ~~local~~ *health care* stakeholder advisory committee established pursuant to Section 14087.484 for this purpose.

(d) The department shall make the results of the evaluation available to the public, which shall include, at a minimum, publishing the evaluation on the department's Internet Web site.

(e) The department shall make recommendations for the continuation, expansion, or termination of the pilot program in the affected counties based in part on the evaluation results. ~~The recommendations may include, but need not be limited to, mitigation measures to further protect access to care for uninsured persons and to ensure the financial viability and stability of the safety net hospitals and clinics.~~

~~14087.492.~~

14087.494. This article shall become inoperative on July 31, 2015, and, as of January 1, 2016, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2016, deletes or extends the dates on which it becomes inoperative and is repealed.

O